

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/31/2013	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/23/2013.</p> <p>This visit was in conjunction with the PSR to the Investigation of Complaints IN00134737 and IN00134907 completed on 8/23/2013, the PSR to the investigation of complaint IN00137394 completed on 10/4/13, and the investigation of complaint IN00138719.</p> <p>Survey dates: October 30 and 31, 2013</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Survey Team: Tina Smith-Staats, RN, TC Karen Lewis RN Jason Mench RN</p> <p>Census bed type: SNF/NF: 129 Total: 129</p> <p>Census payor type: Medicare: 20 Medicaid: 96 Other: 10 Total: 129</p> <p>Sample: 15</p> <p>Signature Healthcare of Muncie was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/31/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF MUNCIE			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	Continued From page 1 Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00134747 and IN00134907. Quality review completed on November 6, 2013 by Randy Fry RN.	{F 000}			